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ABSTRACT

As part of a series of reports designed to support the implementation of Proposition 10: The California Children and Families Act and to provide comprehensive and authoritative information on critical issues concerning young children and families in California, this report examines the current situation for children who have been maltreated by their parents and who are served by the child welfare system. The report provides background information on the current design of the state's child welfare system and data on the numbers of children affected by maltreatment. The report also describes how young children are disproportionately affected by child maltreatment and how their unique vulnerabilities are exposed and often exacerbated by the system. Some of the problems currently affecting child welfare are described, and a series of innovative program approaches are offered that suggest alternative service designs that are now being implemented for young children. The report asserts that Proposition 10 commissioners have the opportunity to offer both financial assistance as well as a fresh perspective on the developmental needs of young children and the factors associated with healthy development, and thus can have a positive impact on truly disadvantaged children. Finally, the report argues that by focusing on preventive services for vulnerable families, catalyzing coordination among existing service systems, and targeting service delivery to the critical transition points in children's lives, the developmental trajectory of many youngsters may be improved considerably. The report's two appendices list useful organizations and experts and identify child welfare funding sources in California. (Contains 111 references.) (KB)

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Building Community Systems for Young Children

Building Community Systems for Young Children is a series of reports designed to support the implementation of Proposition 10: The California Children and Families Act. Each installment is written by a team of experts and provides comprehensive and authoritative information on critical issues concerning young children and families in California.

March 2001

Foster Care and Adoption:
How Proposition 10 Commissions Can Help California's Most Vulnerable Young Children

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Foster Care and Adoption:
How Proposition 10 Commissions Can Help California's Most Vulnerable Young Children

I. Introduction

The opportunities for growth and development in the early years are unprecedented, while the chances for making a lasting difference in the lives of young children are equally grand. This report examines the plight of the youngest, most vulnerable children in California: children who have been maltreated by their parents and who are served by the child welfare system. These young children, representing the majority of children in foster care, and the majority waiting for adoption, deserve a better chance if they are to grow up as healthy, productive citizens.

Investments in the well-being of the youngest children in California's child welfare system offer both opportunities and challenges. Since California has more children in the its child welfare system than any other state, it could be a powerful force for developing innovative programs benefiting large numbers of vulnerable children. The child welfare system is a large, complex array of programs that involve public and private child-serving agencies, the juvenile courts, the police, and community members at large. The system is not well organized, and the families served often face multiple challenges.

Nevertheless, the child welfare system is undergoing a remarkable period of transformation. Policymakers and program managers are turning their attention to this once neglected field, and they are attempting to reorganize it to better serve the needs of children and families. New service delivery models that are family-focused, child-centered, and community-based are arising that attempt to promote child well-being within the context of stronger families. The child welfare system—traditionally focused only on protecting children from serious harm—is placing a greater focus on prevention through family support programs that promise to serve children and families before they get in trouble. Rearing children is no easy task, and all families face certain vulnerabilities over the life course. As the child welfare system continues to evolve, new service paradigms are developing that offer preventive services that address family vulnerabilities early on.

Although the child welfare system offers the promise of renewal, the current system is plagued by a variety of problems. These difficulties affect the youngest children most severely. The advent of Proposition 10 offers an exciting and important opportunity to leverage other funding sources in order to replicate promising programs, to design new initiatives targeted at very young children in foster care, or to support those children waiting for or recently adopted into new families. The number of young children affected by maltreatment is a tragedy our communities are not currently equipped to handle; Proposition 10 can help to target attention to these most vulnerable children, garner support for integrated, coordinated strategies, and help propel public and private agencies toward more thoughtfully designed services that will enhance young children's growth and development.

This report will provide background information on the current design of the child welfare system, and data on the numbers of children affected by maltreatment (neglect and physical, sexual and emotional abuse). The report will describe how children, from newborns to age 5, are disproportionately affected by child maltreatment, and how their unique vulnerabilities are exposed and too often exacerbated by the system. Some of the problems currently affecting child welfare will be described and a series of innovative program approaches will be offered that suggest alternative service designs that are now being implemented for young children.

The potential offered through Proposition 10 is not just financial. As this report suggests, the children served through the child welfare system could arguably be considered the most vulnerable in the state. Their participation in the child welfare system often magnifies their vulnerability for one reason or another: the experiences associated with multiple placements while in care; lengthy separations from birth parents; premature reunification with parents who do not have the necessary resources and supports to provide healthy parenting; the paucity of high-quality foster homes and the lack of support for foster parents; or ill-planned transitions from one home to another. Proposition 10 commissioners have the opportunity to offer both financial assistance as well as a fresh perspective on the developmental needs of young children and the factors associated with healthy development. These tools can affect the systems that touch young children's lives, and therefore have the potential for widening the impact on truly disadvantaged children.

The urgency of the crisis in child welfare services cannot be overstated. In 1999, over 622,000 child maltreatment reports were received by county social services agencies across California (California Department of Social Services), representing approximately half a million children (Needell et al., 2000). With the overall growth in child abuse reporting in the last decade came an expansion in the foster care caseload as well. As of July, 2000, over 107,000 children were living in out-of-home care (Needell et al., 2000), a growth rate of over 50% over the past decade. Among the children living in foster care, many are very young. In fact, the child welfare system is dominated by young children. Over half of all children entering foster care are under the age of 6 (Needell et al., 2000). Across the state, more than 1% of infants will reside in foster care at some time during their first year of life, and for many it will be every day of that year. Berrick et al. (1998) estimate that nearly 3% of all young children will experience such grave threats to their well-being that they will be placed in foster care at some point before age 6.

For our society to thrive, children should progress through the early years free of influences that might diminish their capacity to learn and grow. The first few years are a critical developmental period for the optimal growth and maturation of all children. Major developmental advances start in the womb, when fetuses take shape, their brains develop, and their nervous and circulatory systems are established. In infancy, young children begin to learn about the external world, including its sights, sounds, tastes, and smells. Infants have the opportunity to develop their first relationships from the moment of birth, when they are held, spoken to, fed, comforted, and when their cues and signals are responded to sensitively. These early experiences give organization to children's development and influence their capacity for future development and relationship skills (Perry et al., 1995). The hallmark of the early years is significant exploration and constant learning—testing the environment, mastering skills, and developing new strategies for communication. Throughout this

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period, building relationships with others—first with parents and then with other children—is a key feature of the early childhood experience.

The majority of children are reared by their biological parents and have the advantage of developing within an environment marked by consistency. The ability of parents to provide safe, stimulating, and nurturing homes for children varies considerably, but most parents are able to provide basic care and protection for their young children. Many families are sometimes overwhelmed by the demands of parenthood. However, raising young children can be particularly demanding when parents are faced with unstable incomes or jobs, great personal stress, depression, cognitive impairments, substance addiction, or isolation from friends (Burgess & Conger, 1977; Steinberg, Catalano & Dooley, 1981; Wolfe et al., 1985; Wolock & Horowitz, 1979). These are the families who are the most likely to maltreat their children and to come to the attention of the child welfare services system. Unfortunately, the large majority of these children will have little direct or lengthy contact with the services or supports of this system as it exists today. This fact alone, if challenged and changed, could make a substantial difference in the lives of many Californians. Because families are usually turned away from the child welfare system, with little to no support offered, many children return to the system weeks or months later, more severely harmed by their parents (Inkelas & Halfon, 1997).

For the children who arrive in foster care, many do so medically compromised, developmentally delayed, and emotionally traumatized by their early experiences. As will be discussed in this report, the youngest children served by the system may arrive with the greatest array of health, mental health, and developmental needs. For young children who are placed in foster care, their advocates are few. Services are often uncoordinated, service needs are undetected or ignored, and even well-intentioned caregivers are often stymied by lack of funding services.

The child welfare system, which has grown to serve rapidly increasing numbers of very young children, was designed with a relatively undifferentiated view of children, leaving the unique developmental needs of infants, toddlers, and preschoolers largely ignored. Yet with every challenge in the child welfare system comes an important opportunity to make a significant difference in the lives of children. Proposition 10 offers an unprecedented occasion to mobilize support for children and families. By focusing on preventive services for vulnerable families, catalyzing coordination among existing service systems, and targeting service delivery to the critical transition points in children's lives, the developmental trajectory of many youngsters may be improved considerably.

II. The Child Welfare Services System in California

System Goals

California's child welfare system is a continuum of overlapping programs and services available to children who have been abused or neglected, or who are at risk of abuse or neglect. Accordingly, the single most important goal of the child welfare system is to *protect children* from maltreatment by their parents or other caregivers.

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The child welfare system also strives to *support families* by promoting the obligations of parents and caregivers to raise children to the best of their abilities. Sometimes, though, parents and caregivers cannot or do not meet the safety and emotional needs of their children. In these instances, the child welfare system aims to *promote permanency* for children.

Permanency begins with family preservation and reunification of children with their families. When these efforts are not successful, the child welfare system aims to place children with other families who can meet their long-term safety, developmental, and emotional needs in permanent, legal family arrangements. Though definitions of permanency sometimes vary, permanency achieved expediently is in children's best interest.

Another goal of the child welfare system, one that needs greater emphasis, is to promote the young child's physical, emotional and cognitive well-being, in accordance with the Federal Adoption and Safe Families Act of 1997 (Public Law 105-89). Although this goal is presumed to be partially met by supporting the family, protecting children and promoting permanency, in practice this goal has been given relatively less emphasis because of many difficulties (cited later) in the child welfare system.

Child Welfare Policy Overview

Two decades ago, the federal government passed the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272), America's first explicit child welfare legislation. The major goals of this Act were to (1) reduce unnecessary out-of-home care placements by requiring reasonable efforts to prevent placement, (2) safely reunify children with their families when possible, (3) limit the time available for reunification, and (4) place more children into adoptions when they cannot return home (Legislative Analyst's Office, 1996).

Federal funding for child welfare services were provided through Titles IV-B and the newly created Title IV-E of the Social Security Act. Title IV-B, the Federal Child Welfare Services Program, is the major source of federal support for protective and preventive services for abused and neglected children and their families. Title IV-B funds offer a capped entitlement to states with the federal government providing 25% of costs to the states' 75% match. In 1996, total federal costs for Title IV-B were an estimated $442 million (U.S. House of Representatives, 1998); total Title IV-B costs for California were an estimated $48 million (U.S. House of Representatives, 1996). Title IV-E, the Federal Foster Care and Adoption Assistance program, is the primary funding mechanism for children who have been placed in out-of-home care (Liederman, 1995). Unlike Title IV-B, Title IV-E funds provide an *uncapped* entitlement at a 50% matching rate for all TANF-eligible children in foster care. Title IV-E funds also provide funding for the adoption of children with special needs and support for youths who transition from out-of-home care to independent living.

Although the 1980s saw few large-scale federal initiatives in child welfare, the 1990s were a time of important child welfare reform. Funding for family preservation and support services were authorized in 1993 and expanded again in 1997. Laws to promote permanency for children of color (MEPA & IPA – P.L. 103-382 & 104-188) and provisions to offer services to older youth leaving care (Foster

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Care Independence Act, 1999) were also enacted. Recent legislation has helped to fortify the fundamental philosophy endorsed by P.L. 96-272. In 1997, for instance, the Adoption and Safe Families Act (ASFA) (P.L. 105-89) was enacted to clarify that the safety of children is the premier goal of the child welfare service system and that their safety should not be compromised by the pressure to preserve or reunify families. The Act also sought to limit the period of reunification services for families wishing to bring their children home from out-of-home care. Under this new federal law, county child welfare workers are required to make reasonable efforts to reunify children with their parents for up to 12 months. If, after 12 months of services parents are unable to care for their children, courts and child welfare agencies are encouraged to develop permanent placements for children, including adoption or legal guardianship.

Although new funding for family preservation and support services were authorized by ASFA,[1] little was done to change the fundamental fiscal structure of the child welfare system. Thus, preventive services that might support child well-being and family development are not central to the financial infrastructure of the current system.

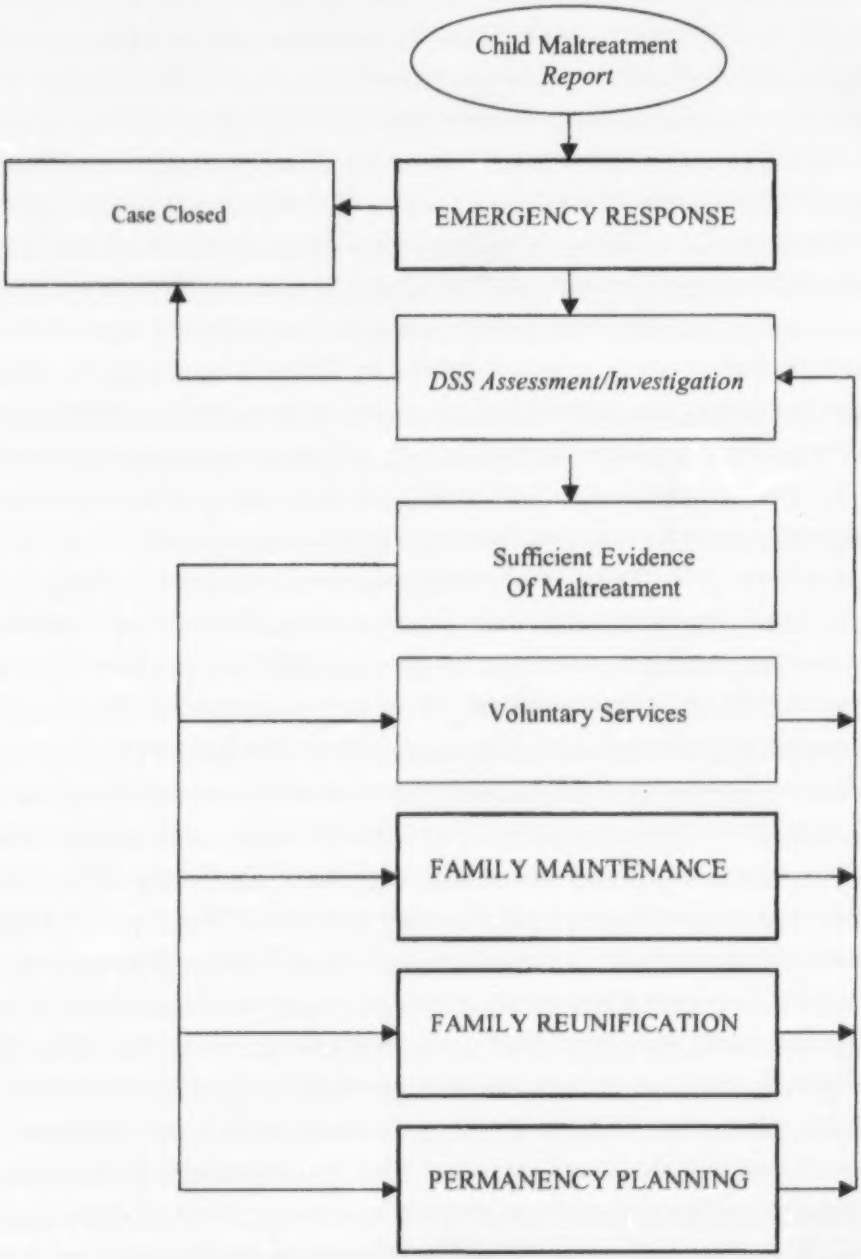
Child Welfare Service Design

The child welfare system is extremely complex and often confusing for public policymakers, county administrators, and social work practitioners to navigate. It is hard to imagine just how difficult and confusing the experience might be for children. The outline below is a guidepost to the general design and construction of child welfare programs across the state; variation may be significant, however, at the local level, particularly because California's child welfare system—unlike that of some other states—is county-administered and considerable discretion is allowed at the local level.

County child welfare agencies are responsible for investigating allegations of child abuse and neglect, and for providing case management and supportive services to children and their families. Entrance into the child welfare service system usually begins with a report of child maltreatment. When such a report is made, county child welfare workers must determine whether the case should be pursued through a child welfare "investigation" or referred to other social services agencies. It is at this point that a child who is an alleged victim of maltreatment, and the child's family, enters the formal child welfare system. The child welfare system consists of five main components: (1) Emergency Response, (2) Family Preservation, (3) Family Maintenance, (4) Family Reunification, and (5) Permanent Placement.

[1] Subpart 2 of Title IV-B, known as "Promoting Safe and Stable Families," provides an additional $305 million in FY 2001.

Children's Pathways through the Child Welfare System

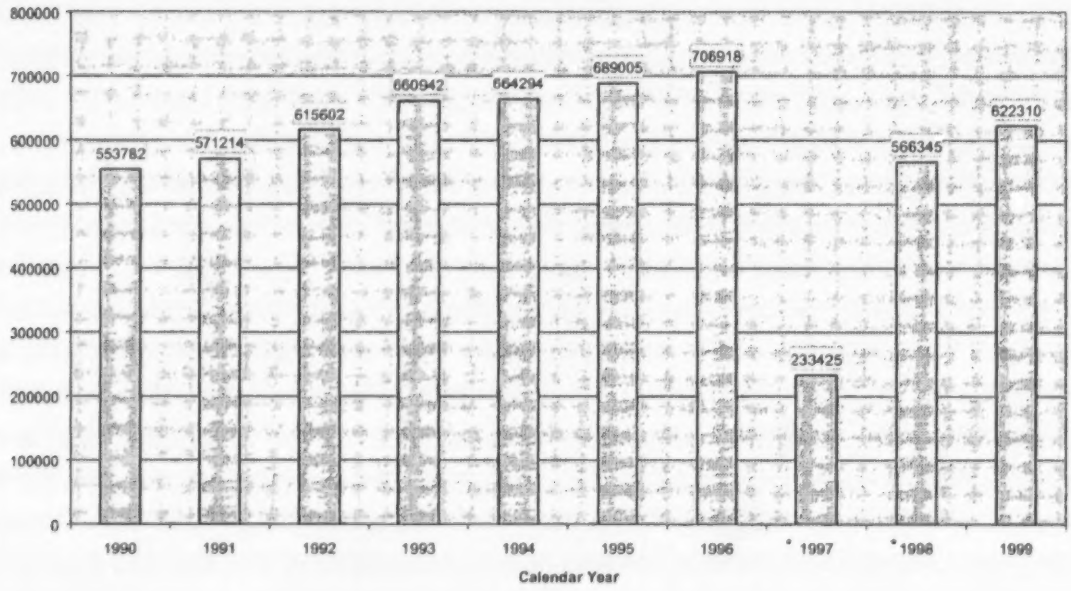


Child abuse and neglect are serious and growing problems in California and the rest of the nation. California state law regards child abuse as (1) physical injury inflicted on a child by another person, (2) sexual abuse, or (3) emotional abuse. Child neglect is defined as negligent treatment that threatens the child's health or welfare (Legislative Analyst's Office, 1996).

State law requires certain professionals to report known or suspected child maltreatment. Legally mandated reporters include workers in child protective agencies; clinical social workers; school teachers and counselors; employees of day care facilities; nurses and physicians; and commercial film and photographic print processors. About 54% of child abuse and neglect reports are made by legally mandated reporters.

Since 1980, the number of child maltreatment reports and the number of children in out-of-home care in California has risen dramatically (Department of Finance, 1996; Needell et al., 2000). Between 1985 and 1989, the number of abuse and neglect reports increased 70%. Since 1989, however, the rate has increased more slowly, and rates have remained relatively stable throughout the latter half of the past decade.

California Child Abuse Reports, 1990 - 1999



* During FY 97/98 counties were converting to CWS/CMS

Source: California Department of Social Services

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The actual occurrence of maltreatment in California is likely higher than indicated by the number of reports made each year. Because of this, and because multiple reports can be made for a single child, it cannot be determined how much of the increase in reports is due to an increase in the number of children being abused and neglected and how much is due to an increase in the number of reports being made per child. Nevertheless, California has one of the highest totals of reports in the country and the largest totals of children in out-of-home care (Department of Finance, 1996; Legislative Analyst's Office, 1996). A report of maltreatment prompts a response from the child welfare system, which is designed first to assess subsequent risk to the child and then to offer necessary supports in order to promote the child's continued safety, usually in the context of a family.

In California, state law requires county child welfare agencies to maintain a round-the-clock ***Emergency Response (ER)*** system designed to respond to reports of child maltreatment (Department of Finance, 1996). Once a child maltreatment report is received by the county child welfare agency, decisions are required immediately regarding whether the child can remain safely at home (Barth et al., 1994). At this stage of the process, a county child welfare worker (usually called a "screener") determines through a telephone assessment with the reporting party whether an in-person investigation is necessary. Statewide guidelines for screening reports exist to assist and facilitate uniformity among counties. While many families may not be appropriate for the protective services offered by the traditional child welfare system, many of the children screened out could likely benefit from a voluntary, preventive approach. Primarily because of lack of funding and fragmentation of services, however, few families ever receive the support that might make a real difference.

Depending on their severity, cases assigned for investigation either require immediate attention (within 24 hours) or intermediate attention (within 3 days); or the case may be assessed as less serious and thus require a response within 10 days. During an investigation, the child welfare worker usually visits with the child, the caregiver, and other relevant parties in order to detect the risk of maltreatment to the child. A case may be closed or offered services. If the child requires out-of-home protection, a *detention hearing* is held, and if approved by a county juvenile court judge, the child may be temporarily legally detained. Should the child require continued out-of-home placement, a *jurisdictional hearing* is held so that the court can decide whether abuse or neglect has occurred as stated in the dependency petition. If no abuse or neglect is found, the case is dismissed. If, however, evidence of maltreatment can be established, a *dispositional hearing* will be held to determine the child's placement (the noncustodial parent or a relative is the preferred placement option), and to establish the parent's plan for services. Once placed in out-of-home care, *judicial review hearings* are generally held every six months to review family maintenance or family reunification efforts.

Child welfare agencies may also offer services to children and their families without involving the juvenile dependency process. This can occur only if there is a *voluntary agreement* for services between the family and the county social services agency. In California, the proportion of families receiving such services varies greatly by county.

When families are mandated to receive services from a child welfare agency, juvenile court oversight is required. Families may receive either in-home services (i.e., "family maintenance" services –

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discussed below) or out-of-home services (i.e., "family reunification"). If after 12 months of family reunification services these efforts are judged to be inappropriate or unsuccessful, a *permanency planning hearing* is held to determine the long-term plan for the child. The plan must include one of the following goals (ranging from the most permanent to least permanent): (a) adoption, (b) legal guardianship, or (c) another planned permanent living arrangement

Of the total number of children reported for maltreatment in California in 1999, about 23% (approximately 110,000) were substantiated. Whether maltreatment was substantiated or not, very few children received any services from child welfare agencies. Data from the California Department of Social Services (2000) suggest that 24% of child abuse reports were immediately screened out, 50% were "closed" following an in-person investigation, and 21% were closed following short-term services and referral. 3% of cases were provided in-home Family Maintenance services, and 2% were provided out-of-home Family Reunification services. A number of studies of California's child welfare system suggest that a large proportion of children reported for maltreatment return to the system repeatedly before their plight is taken seriously (Berrick et al., 1998; Frame, in press; Gilbert, Karski & Frame, 1996; Inkelas & Halfon, 1997). Many of these children – whose maltreatment has been confirmed, and who could likely benefit from services – often do not qualify for assistance because the threshold for action on the part of public agencies is set quite high. There is considerable intercounty variability in the proportion of child abuse reports that are substantiated, and the proportion of children receiving services. Differences may be due to a number of factors including county philosophy and policy, system capacity, or individual worker discretion.

In-home services such as ***Family Preservation (FP)*** and ***Family Maintenance (FM)*** provide support and services to children and families to prevent further abuse and neglect. Generally, these services are targeted toward the parent or caregiver and include services such as counseling, parent training, respite care, and temporary in-home care. Compared with the previous decade, fewer California families are receiving family maintenance services. This suggests that those children and families who, a decade ago, would have received family maintenance services are now receiving no services at all, or that the children are being placed in out-of-home care (LAO, 1996). More families, however, are receiving family preservation services, and local agencies are working to develop better networks of nonprofit providers to offer these services.

State funding is available to support families receiving ***family maintenance*** services for six months. If after six months the family is not able to provide adequate care for the child, the county agency may continue delivering in-home services while supporting the costs through county dollars or place the child in out-of-home care with federal financial participation.

Family Reunification (FR) provides supportive services to the family while the child is in temporary out-of-home care. These services, targeted toward both children and parents or caregivers, typically include emergency shelter care, counseling, drug treatment, parent training, and teaching homemaking skills. By law, reunification services are time-limited activities designed to prevent or remedy child maltreatment. Unless other action is taken to end the services before the time limitation, reunification services are restricted to 12 months with the possible extension to a total of 18 months. To facilitate

reunification, county child welfare agency staff are required to develop a case plan identifying the service needs of the child and family (Department of Finance, 1996).

In California, there are four principal types of out-of-home care placements: (1) kinship care, (2) foster family care, (3) foster family agency care, and (4) group home care. ***Kinship*** homes do not need to be licensed by the state and include those in which the caregiver is a blood relative of the child. ***Foster family*** homes are licensed homes that provide care to no more than six foster children. ***Foster family agency (FFA)*** homes are certified to operate under nonprofit agencies that provide professional support. FFAs are required by law to serve as an alternative to group home placements. ***Group homes*** are facilities of any capacity that provide 24-hour services and supervision, as well as nonmedical care, to children. Typically, group homes serve children who require a more restrictive setting because they have serious emotional and behavioral problems (LAO, 1996).

Permanency Planning (PP) services are targeted exclusively toward children who cannot be safely returned to their biological families. When permanency has been identified as the case plan goal for a child, as opposed to reunification, the county child welfare agency staff must first determine whether the child should be placed for ***adoption***.

In California, children who are adopted out of the child welfare system are usually adopted through a public or private licensed adoption agency. In these instances, the biological parents have had their parental rights terminated by a court action or have relinquished their parental rights to a licensed adoption agency. There are no legal differences in the roles of public and private adoption agencies. Most licensed private adoption agencies continue to place infants primarily, most of whom are healthy newborns voluntarily relinquished by their biological parents (California Department of Social Services, 1995). (Children can also be adopted independently or through the state's Intercounty Adoptions Program.)

If adoption is not a viable option for a child, county child welfare agency staff must then consider placing the child with a legal guardian. While under the law and in practice ***legal guardianship*** is generally considered second only to adoption in terms of degree of permanence, this option is often ignored in discussions of permanency planning. Guardians are charged with the care of a child and given authority to make decisions on behalf of the child that a biological parent would usually make, yet guardians are under no legal obligation to support the child financially. Furthermore, unlike adoption, where a child becomes a legal member of the adoptive family, biological parents' rights to a child are not terminated under guardianship; therefore, children's formal and legal ties to their biological family remain intact. In fact, the legal appointment of guardianship can be terminated by successful petition of a parent to reassume guardianship of her or his child. The appointment can also be terminated by resignation, and it ends automatically when a child reaches the age of majority.

One major feature of guardianship contributes to its undesirability as a permanency option. That is, once guardianship is granted, children are no longer eligible to receive social services provided to them as dependents of the child welfare system. Despite this, guardianship can sometimes be seen as a desirable option. Relatives, for instance, can obtain guardianship to secure legal grounds for caring for a child in their home, while maintaining the integrity of the biological family. Caregivers

opting for guardianship also may wish to offer a child a greater sense of permanence than is provided by long-term foster care, or they may want to reduce the intrusion they feel from the presence of a caseworker. Non-kin foster parents who arrange for legal guardianship are paid a stipend similar to the foster care subsidy. California legislation enacted in 1998 also allows kin who elect legal guardianship to receive a subsidy through the "KinGAP" program.

"Another planned permanent living arrangement" is the terminology used in the Adoption and Safe Families Act of 1997 for the third, and usually least preferred, permanency option for children who cannot return to their biological families. Although long-term foster care is not mentioned in this Federal law, in California, this third option is usually most frequently implemented by a court order (subject to periodic review) of long term foster care that refers a child to continued placement in a foster home after a permanency planning hearing has taken place (California Welfare and Institutions Code 366.26). This option is used more often for children who are placed with kin than for children placed with caregivers unrelated to them, and for older children whose removal from a stable foster placement would be detrimental to their well-being.

III. Young Children and the Child Welfare System

Young children are especially likely to come to the attention of the child welfare system. Because of their extreme vulnerability during the first years of life, the risk of severe or even fatal harm from maltreatment is taken seriously by child welfare agencies across the state.

Maltreatment Reports

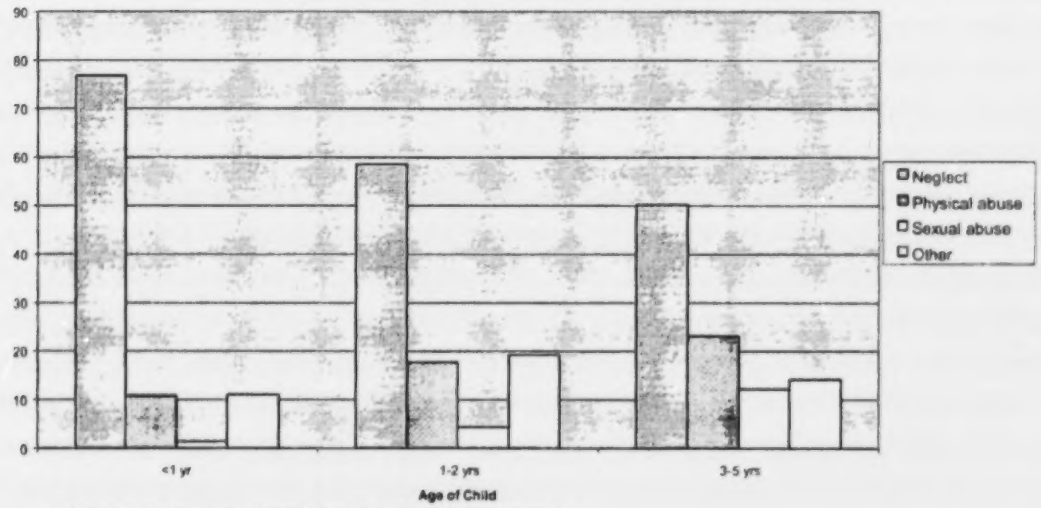
Maltreatment affects a significant proportion of all children each year, and very young children's lives are touched most profoundly. Children under age 6 are the subjects of about 40% of the confirmed reports of maltreatment, even though they represent about one-third of the population of children in this country (National Center on Child Abuse and Neglect, NCCAN, 1996). According to the third and most recent National Incidence Study (NIS-3) of Child Abuse and Neglect (data collected in 1993 and 1994), there has been a 67% overall increase in the incidence of maltreatment since 1986 (Sedlak & Broadhurst, 1996). Among all abused and neglected children, the youngest are the most likely to be the victims of severe injury or death (Sorenson & Peterson, 1994; Straus & Gelles, 1992): 37.9% of the deaths from maltreatment in 1998 were in infants under 1 year, and 77.5% were in children younger than age 5 (U.S. Department of Health and Human Services, 2000).

For obvious reasons, physical maltreatment is extremely serious because its consequences can be severe or fatal. Yet young children are most frequently reported for neglect. This fact is far from a cause for relief, however, since young children's absolute dependence on their parents or guardians means that neglect can compromise their physical health and safety and may also cause significant developmental harm and long-term cognitive and socio-emotional difficulties (Egeland, 1991; Cicchetti & Toth, 1996; Finkelhor, 1995).

Infants, in particular, are especially likely to be reported and substantiated for neglect. Over three-quarters of all infants whose child maltreatment reports are substantiated, are identified as neglected, broadly defined.[2] Child maltreatment – and child neglect in particular – may be exacerbated by conditions of poverty (Drake & Pandey, 1996; Sedlak & Broadhurst, 1996; Spearly & Lauderdale,

Substantiated Child Maltreatment Reports for Young Children, California 1999

20.3% of Children Aged Birth – 5 yrs are Neglected



* *Neglect* defined as "severe neglect," "general neglect" and "caretaker absence or incapacity."
** *Other* defined as "exploitation," "emotional abuse," and "at risk."

1983), parental substance abuse (Albert & Barth, 1996; Jaudes, Ekwo & Van Voorhis, 1995; Sagatun-Edwards, Saylor & Shifflett, 1994), and stressful community conditions (Ards, 1992; Coulton & Pandey, 1992; Coulton, Korbin, Su & Chow, 1995). Other factors associated with neglect include family structure, depression, social isolation, and other family problems (Gaudin & Dubowitz,

[2] "Neglect" includes several categories of maltreatment such as severe neglect, general neglect and caretaker incapacity. "Other" includes exploitation, emotional abuse, and at-risk.

1997; Hartley, 1989; Hegar & Yungman, 1989; Nelson, Saunders & Landsman, 1993), and considerable evidence suggests that child welfare staff consider these cases very seriously (Berrick et al., 1998).

One of the most sobering aspects of the child welfare system is the profound disparity in experience for children of color. African-American children are more likely to be reported for maltreatment than children from other ethnic groups. In one study, Berrick et al. (1998) showed that the rate of maltreatment reporting for African-American infants in California was approximately three times that of Caucasian and Hispanic infants and almost six times higher than for infants in other ethnic groups. They found that by the time African-American children who were born in 1990 reached kindergarten, 39% were reported for maltreatment, compared to 15% of Caucasian children and 17% of Hispanic children.

The association between maltreatment and ethnicity is confounded by issues of poverty and community characteristics; it is made further complex by problems of substance abuse. One study of substance abuse among pregnant women in California indicated that African-American women were more likely than women of other ethnic groups to use drugs (Vega et al., 1993); therefore, African-American children may be at a greater risk of prenatal exposure to drugs. In particular, cocaine and crack cocaine appear to be the drugs of choice among substance-abusing African-American women (Vega et al., 1993), and hospital staff may be more likely to report infants' exposure to cocaine than to other drugs (Sagatun-Edwards, Saylor & Shifflett, 1994). Because criminal penalties are higher for the possession of crack cocaine, these infants may also risk losing their parents to incarceration, thereby being reported for "parental incapacity."

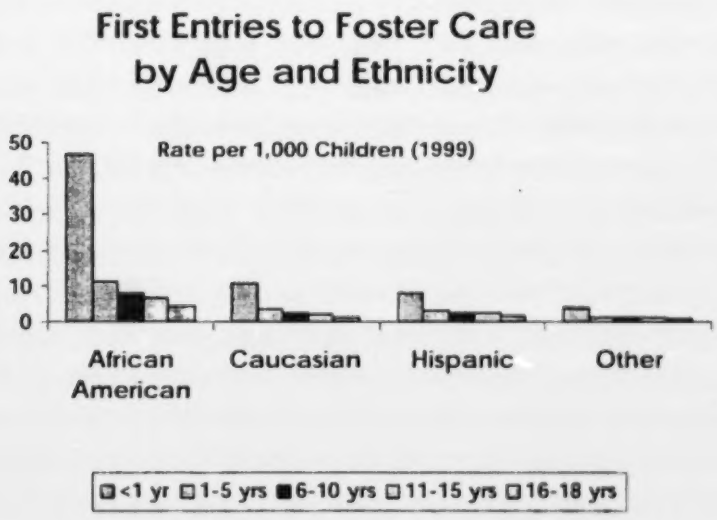
Entries into Foster Care

Although over two-thirds of child maltreatment reports may be screened out as inconclusive or unfounded, over 110,000 children reported for maltreatment in California last year had their reports substantiated. Many of these children and families were provided short-term services through child welfare agencies; some children, however, were placed in foster care because of the nature and severity of the report. Because of their special vulnerability, infants are especially likely to be placed in foster care once a maltreatment report has been received. In fact, infants are more likely to enter foster care than are children of any other age. Data from five major states across the country (California, Illinois, Michigan, New York, and Texas) have shown similar trends (Wulczyn, Goerge & Brunner, 1999). As of 1999, infants (ages 0-1) made up about one-quarter of all new foster care cases in California. Toddlers (ages 1-2) made up about 16% of new entries, and preschoolers (ages 3-5) were 17% of new entries. Therefore, more than 55% of the children who entered foster care in 1999 were under age 6 (Needell et al., 2000). The incidence for first entries to care for infants in California was nearly 14 per 1,000 infants in 1989, but dropped to about 10 per 1,000 in 1997 (Needell et al., 2000). This rate is approximately three times that for children of other ages.

As in trends in maltreatment reporting, African-American children, regardless of age, enter foster care at a much higher rate than do other children. In California, disparities for African-American infants are particularly striking. Nearly 37 per 1,000 African-American infants entered care in 1997,

compared to about 10 per 1,000 Caucasian infants and 6 per 1,000 Hispanic infants. Infants of other ethnic groups entered care at a much lower rate (approximately 3 per 1,000).

Clearly, the lives of many young children are touched by the foster care system. By the time a child begins kindergarten, the chance that he or she has experienced foster care is substantial. Nearly 3% of all 5 year-olds in California have been in foster care at some point, and the same is true for over 10% of African-American children.



Placements while in Care

Of the over 100,000 children currently in out-of-home care in California, about 30,000 are under age six. About half of these young children spend the majority of their time in care with relatives in what is commonly called "kinship care," somewhat less than one-quarter (22.7%) are cared for in foster family homes, and about one-fifth (21.6%) are cared for in foster family agency homes.

While in care, young children's experience could hardly be characterized as stable; youngsters frequently move from one home to another. Children placed with their relatives are much more likely to experience stable placements while in care. Of infants who remain in care with kin for at least two years, about half (48%) experience only one placement while in care. An additional one-third (36%) have two placements, and the remaining 17% have three or more. Infants placed with caregivers other than relatives move more often. About 35% experience one placement, 40% experience two placements, and 26% experience three or more. As children age and remain in care longer, placement instability is more profound. A full 52% of preschoolers (ages 3-5) placed with non-kin for at least *four years* experience three or more placements.

In a landmark study conducted by Fanshel, Finch & Grundy (1990), placement instability was associated with a variety of negative outcomes for children. In fact, in much of the research on foster care outcomes, placement instability appears to be one of the strongest and most conclusive negative determinants (for a review, see McDonald et al., 1996). Recent research highlights the complex relationship between placement history and children's behavior problems and emphasizes that children who initially do not present with behavior problems develop increasingly self-destructive behaviors in response to multiple placements (Newton, Litrownik & Landsverk, 2000).

Exits from Care

Although foster care is designed to provide temporary care for children who cannot remain with their parents, many young children have lengthy stays in care. Over one-third and one-quarter of children under age 6 (placed with kin and non-kin, respectively) remain in long-term foster care.[3] They experience instability (discussed above) and impermanence, as they do not have opportunities to develop lifelong, legal relationships with new families.

About half of young children placed in out-of-home care return to their parents. Of these, however, some are re-placed in care. Infants are the most likely to return to foster care, and evidence from California suggests that between one-fifth and one-quarter of infants who are reunified with their parents return to the child welfare system within 3 years. Efforts to return young children to their parents should be intensive, and supports for families who succeed in reunifying should be comprehensive. Yet some families, regardless of the supports and services available, may not be able to care for their children again. For these, adoption is the preferred goal. In California, adoption rates for children under the age of 6 vary considerably. Children who enter care as infants have the greatest opportunities for adoption. Approximately one-quarter of infants who enter care and are placed with nonrelatives are adopted out of the child welfare system within 4 years. For children who enter care at age 1 or older, their odds of adoption are cut in half.

IV. Special Needs of Young Children Served by the Child Welfare System

When young children arrive in foster care, many have medical conditions, developmental needs, and socioemotional issues that may be profound. The child welfare system has the opportunity to remediate these problems or exacerbate them. An over-burdened child welfare system with overwhelming case loads and little awareness of the special developmental needs of young children is unlikely to systematically repair these vulnerabilities. A review of some of the more challenging problems children bring to care follows:

[3] Long-term foster care is defined here as remaining in care for at least 4 years. Evidence from Berrick et al. (1998) suggests that if children do not return home within the first 2 years of placement, the odds of ever returning home are very small.

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Children's Medical Needs

According to the GAO, children in foster care are, as a group, "sicker than homeless children and children living in the poorest sections of inner cities" (1995, p.1). Children in foster care have higher rates of chronic and acute medical conditions compared to children in the general population, including higher rates of upper-respiratory illnesses, skin conditions, vision problems, growth delay, dental caries, asthma, and acquired immunodeficiency syndrome (Chernoff et al., 1994; Halfon, Mendonca & Berkowitz, 1995; Heisler, 1994; Hochstadt et al., 1987; Simms, 1989; Takayama, Wolfe & Coulter, 1998). Young children often come to foster care with one or more medical problems, with infants having an average of 2.6 conditions, toddlers 1.5 and preschoolers 1.3 (Halfon, Mendonca & Berkowitz, 1995; Silver, 1999). These concerns may go undetected by the child welfare system. Few public child welfare agencies are designed to include comprehensive pediatric and dental examinations for young children entering care.

Children's Developmental Issues

Along with children's medical problems, many young children in foster care experience developmental delays of one type or another. Recent studies identified rates of cognitive impairment in children between 2 months and 5 years as high as 51%, compared with 10% in normative samples (Dale, Kendall, & Schultz, 1999; Halfon, Mendonca & Berkowitz, 1995; Jaudes & Shapiro, 1999). Delays in gross or fine motor skills may be left undetected by hurried social workers, or untrained foster or kin caregivers (Orlin, 1999), and speech and language problems are more prevalent among the foster care population than among children in the general population (Amster, Greis & Silver, 1997; Halfon, Mendonca & Berkowitz, 1995; Hochstadt, et al., 1987; Simms, 1989).

Children's Socioemotional Issues

Researchers and professionals are becoming more aware of the mental health needs of infants and toddlers; young children served by the child welfare system may be at particular risk of having or developing special vulnerabilities in these areas. Because of their exposure to family violence, substance abuse or neglect, compounded by conditions of poverty and frequent changes in placement the socioemotional needs of these children may be profound. According to Morrison, Frank, Holland and Kates (1999), children in foster care may suffer from posttraumatic stress disorder, disturbances in self-regulation (e.g., aggressive behavior, short attention spans, high impulsivity), attachment disorder, depression, and anxiety. Halfon and colleagues (Halfon, Mendonca & Berkowitz, 1995) report that 84% of children from infancy to age 5 in foster care have either emotional or developmental problems. Review studies suggest that about one-half to two-thirds of children entering foster care exhibit behavior or social competency problems that necessitate treatment (Landsverk & Garland, 1999).

In spite of the need for mental health services among children in care, a good deal of evidence suggests that children's mental health needs may not be met by the current system. Halfon & Klee (1987) estimated that 60-70% of California's foster children suffered from a mental health problem, yet only about 20% of children received public mental health services (Halfon, Berkowitz & Klee,

1992). More recent surveys of mental health services utilization indicate that 21% of children in foster care aged 2 to 3 and 41% of children aged 4 to 5 received mental health services (Landsverk & Garland, 1999; Blumberg et al., 1996).

Family Factors

The challenges young children in foster care experience are likely related to the difficulties their parents and other family members face as they struggle against the effects of poverty, distressed neighborhoods, unemployment, and other environmental assaults. Parents of children involved in the child welfare system have high rates of domestic violence (Findlater & Kelly, 1999; Mills, 2000), mental health problems (Kotch et al., 1995), and substance abuse (Chaffin, Kelleher & Hollenberg, 1996). In one study of infants placed in foster care in California (Frame, Berrick & Brodowski, 2000), 84% of mothers had significant substance abuse problems, 68% had documented engagement in criminal activity, half of the women were victims of domestic violence, and about two-fifths had been abused and neglected as children, themselves. Furthermore, almost two-thirds of the mothers had some identified mental health problem—most often depression—many had educational disabilities, including learning disabilities, and over one-third were either homeless or living in precarious housing circumstances.

V. Problems with the Current Child Welfare System

The special needs of children and families coming to the attention of the child welfare system demand a service response that is comprehensive, intensive, culturally respectful and developmentally sensitive. Instead, many aspects of the current system are flawed—some by design, and others by circumstance.

Fragmentation of Responsibilities

Collaboration among the professionals who serve maltreated young children is very difficult to achieve. This is in part due to the fact that these children are often involved in multiple service systems, none of which have total responsibility or oversight accountability. Lack of collaboration and coordination, which may occur whether children are living with biological families, in foster care, or adoptive placements, all too often results in young children receiving inadequate or fragmented care.

Effective coordination is hampered by a variety of factors. For example, federal, state, county, and privately funded programs involved in service delivery often have separate funding streams, mandates, eligibility requirements and restrictions. In addition, the philosophical framework driving services may differ, resulting in professionals functioning in isolation from one another (Little Hoover Commission, 1999). Numerous other obstacles exist, including concerns about confidentiality; lack of training and information about other professions and agencies and their respective roles; heavy workloads; time constraints; and high staff turnover.

Agency Issues

Child welfare agencies across the country are overwhelmed by the number and complexity of cases. The agencies, social workers, and clients suffer from excessive caseloads and high staff turnover. For example, in Los Angeles County, many social workers have caseloads as high as 70, when the ideal standard set by the Child Welfare League of America is one-third as high. Estimates of the turnover rate for child welfare staff are hard to find. In Los Angeles County, turnover estimates vary from 12% per month, to 10% per year (Gurwitt, 1988). These issues are particularly pronounced in Los Angeles County, where the largest percentage of the state's foster children reside.

When caseloads are too large and staff turnover is high, social workers are not able to deliver critical services to young children and their caregivers. Social workers focus on minimal court requirements and crises, but they have less time for the important yet nuanced tasks associated with thoughtful placement decisions, preparation for children and foster parents, supportive services for caregivers, and accessing assessments and services to optimize children's health and development. For children moving toward adoption, little time is available to facilitate a smooth transition, and services following placement may be scarce (Berrick et al., 1998).

Inadequate Records

A complete history of the child, including information about birth and medical complications, developmental functioning, and psychosocial history, is critical in order to meet the needs of young children in foster care. But many children's records include significant gaps in all or most of these areas. Reasons for the gaps in records are multiple: the biological parents' neglect of their own and their children's medical and mental health; the emergent circumstances necessitating the children's removal, which rendered records unavailable; child welfare workers' high turnover rates; time constraints; misguided confidentiality concerns; and multiple placements of children (Institute for Research on Women and Families, 1998; Silver et al., 1999). The Child Welfare League of America and the Academy of Pediatrics (1994) set guidelines for health care for children in foster care, including a health passport that follows the child from one placement and one provider to another. However, many agencies have not fully implemented these recommendations (Halfon and Klee, 1992; Los Angeles County Commission for Children and Families, 1999-2000).

Background information is critical in preparing foster and adoptive parents for caring for a new child. With incomplete information, parents may develop unrealistic expectations for the child. The discrepancy between what they expect and the reality of the child's difficulties and behavioral problems can lead to disappointment and even disruptions in the placement. Research has shown that the better the preparation, the more satisfied foster and adoptive parents are with the placement (Barth & Berry, 1988; Edelstein et al., 1995; Edelstein et al., 2000; Rosenthal & Groze, 1992). Foster and adoptive parents can make more thoughtful decisions about the child's care when provided with accurate and comprehensive information and anticipatory guidance.

Multiple Placements

Placement moves may be especially problematic for very young children as they struggle to develop a foundation for attachment, empathy, trust and expression. Preschool children, during the "egocentric" stage of development (Piaget, 1960), may feel responsible for the placement change, blaming themselves for "bad" behavior. Thus, children can experience each new placement as a evidence of their badness, diminishing their already fragile self-esteem. In addition, each placement change represents rejection and interferes with their trust in caregivers (Rosenfeld, 1997) and the development of attachment, essential to the development of emotional security and social conscience (Lieberman & Zeanah, 1995; American Academy of Pediatrics, 2000). Multiple placements further victimize those young children who are already injured by their life circumstances (Stone, 1995). The same dynamics hold for adoptive placements that disrupt; a previous disruption significantly increases the likelihood of a second disruption (Barth and Berry, 1988; Groze, 1986). Nonresponsive, abusive prior family relationships often leave children with behavioral and emotional problems; multiple placements render these vulnerable children less trusting, less adaptable, and more behaviorally challenging, posing difficulties for new foster or adoptive parents.

Many factors contribute to the frequent changes in young children's placements. Excessive caseloads and lack of expertise on the complex and multiple needs of young children make it very difficult for child welfare workers to adequately match children's needs with the qualities and abilities of foster and adoptive parents. In addition, the ongoing decline in the foster parent census (CWLA, 1991) means significant shortages of foster and fost/adopt homes[4] for young children—particularly those with special needs. The dwindling supply of foster parents is driven, in part, by the increasing number of women who now work outside the home, as well as greater numbers of single-parent families (Mauro et al., 1999); when these families decide to take on foster children, the challenges of providing care may become especially pronounced.

Foster and adoptive parents are often inadequately prepared for their work with special-needs children. Further, few services are available that focus on developmental guidance for caregivers of these children. Such assistance, offered before major crises occur, could help caregivers understand how children's background, history, temperament, and developmental delays can contribute to children's challenging behaviors. Without an understanding of these dynamics it is difficult to develop interventions and parenting strategies to address these problems.

[4] Foster-adoptive placement means placing children with adoptive families on a foster care basis before the children are legally free for adoption. These placements are those in which the expectation is that the foster parents will eventually adopt the child so that children not suffer multiple placements and that a permanent plan for children be established as early as possible.

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Johnny and Kenneth

Johnny and Kenneth, age 2 and 4, were placed on a fost/adopt basis with Mary, a single mother who had hoped to adopt them. The boys were placed in foster care when Johnny was found to have been born prenatally substance-exposed. The boys had since lived in three foster homes, including one fost/adopt home which they had been told would be their "forever family." The boys had been removed abruptly from the previous foster home at the foster family's request—the caregivers indicated that the boys were too active, fearful, and destructive. Mary was eager to make a home for these siblings, and was sensitive to their backgrounds. However, an uncle of the biological mother decided he wanted to assume care of the children, and was going to contest the adoption. On the one hand, Mary was struggling to facilitate the siblings' attachment to her, to ease their fears of further abandonment, and to develop effective parenting strategies in dealing with their difficult behaviors. On the other hand, she was becoming increasingly unsettled by the actions of the relative. The children became more anxious and fearful as a result of her uncertainty and their own ambivalence about where they belonged. Their behavior became even more difficult to manage. Before long, Mary was not sure she could parent the children successfully under these difficult circumstances. Fortunately, Mary was able to utilize the services of a specialized program called TIES for Adoption (described later). She started attending a support group for parents where she learned that many other families had experienced complications with the legal process, but had made it through this stressful period. The group facilitators and the other group members helped her understand her situation and the children's experience. Mary also received individual parent counseling and the children received play therapy. Eventually, the uncle stopped his pursuit of custody and Mary and the boys settled in. The boys' adoption has since been finalized and they are doing well in school, and together they are building their new family.

Inadequate or Absent Assessments

Skilled, developmentally appropriate psychological evaluations of young children in the child welfare system are a first step in identifying and planning for the mental health needs of the children. However, some of the evaluations conducted are of poor quality (Halfon et al., 1995; Rosenfeld et al., 1997; Edelstein et al., 2000). Sometimes children are evaluated right after a move, when they may be most vulnerable and their behavior is most disorganized. Sometimes evaluators are not familiar with young children and the special needs and vulnerabilities of youngsters in the child welfare system. Further, children may not be well evaluated within their context (e.g., the impact of a less-than-optimal foster home setting) or across contexts (e.g., preschool teachers often are not queried about children's functioning). As a result, the focus tends to be primarily on the children's behavioral problems or symptoms. Such assessments too often lead to erroneous conclusions that delay or result in inappropriate permanency planning. For example, 2 year-olds assessed shortly after moves to new foster homes may be diagnosed as "defiant and oppositional" without supporting evidence. These labels and diagnoses become part of children's permanent record and may discourage and misinform prospective adoptive parents (Edelstein et al., 2000).

In other instances, children in the child welfare system do not receive evaluations at all and therefore do not receive early intervention services to which they may be entitled. Many children sorely need these services in order to mitigate the biomedical and environmental risk factors that place them at

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great risk for poor developmental outcomes. Monitoring high-risk children's developmental progress on a regular basis provides the opportunity to identify needs and intervene early when services are most effective (Halfon et al., 1995; Rosenfeld et al., 1997; Edelstein et al., 2000; American Academy of Pediatrics 2000). The following vignette exemplifies missed opportunities for psychological evaluations that could have led to early identification and intervention for foster children with multiple risk factors.

Mary

Mary is a 2 year-old African-American child of small stature born to a mother who had received no prenatal care. Mary's toxicology screen was positive for cocaine at birth, and her mother reported a history of chronic cocaine and alcohol use. Because of jitteriness and sepsis, Mary was hospitalized for 12 days following birth. She was then placed in a foster home, where she remained for 18 months. She was removed from this home and placed in another because of overcrowding and inadequate stimulation. Mary never had a developmental evaluation, and was reported by all involved to be a well child whose development appeared to be on target. When her background information and picture were presented to prospective adoptive parents, they raised concerns about possible facial features of fetal alcohol syndrome. The TIES (program described later) interdisciplinary staff then conducted a developmental evaluation of Mary, and also made a referral to a physician specializing in medical genetics. The genetics consultation revealed that some but not all of the characteristic facial features of fetal alcohol syndrome were present, and that there was evidence of organic brain damage. Developmental testing indicated that Mary functioned in the significantly delayed range, mostly performing at the 12-13-month level. Mary had many strengths, of course; she was social, playful, cooperative and humorous, as well as adorable. The prospective adoptive family had Mary placed in their home, as they felt they had full information and could count on the provision of much needed supports in the future. With a developmental assessment in hand, the Regional Center accepted Mary for immediate services. Nevertheless, she had missed early intervention services for the first 2 years of her life, and she had almost been placed as a child whose development was "fine."

Inadequate Preventive and Treatment Services

Child welfare agencies have traditionally focused on the safety and protection of the children in their custody. Unfortunately, prevention services that can identify and treat at-risk children and their physical, developmental and mental health problemshave received short shrift. Even the few services and scant research which address children's developmental and growth delays rarely emphasize or target for intervention the underlying emotional disorders and difficulties with attachment for children under age 5 (Rosenfeld, 1997; Halfon, 1995; Kronstadt, 1999; American Academy of Pediatrics, 2000).In addition, service delivery models and reimbursement structure often do not take into account that when young children receive services for mental health issues, their caregivers need to be included in the treatment plan (Shirk, Talmi & Olds, 2000; Silk et al., 2000).

Few foster or adoptive parents receive the preparation, education, and support they need to provide the therapeutic care that these sometimes challenging young children need. Children and/or their caregivers are rarely provided with a safety net of comprehensive, high-quality family support

services when children are placed in out-of-home care, during their stay in care, and following children's transitions out of foster care. Such services would likely lower the odds of reentry into the system for these vulnerable children.

The reasons why young foster children's needs are left unattended include a paucity of mental health professionals trained to work with this population, and few integrated service programs available to offer such services. Some programs and professionals that could provide such services are unwilling to accept Medi-Cal payments because of the low reimbursement and high paperwork demands. Some others who do provide services may resort to a primarily pharmacological approach as a strategy for managing children's disturbed behavior—partly because they subscribe to a disease model of mental illness and equate children's behavioral and emotional problems primarily with organic disease states, and partly because high-quality assessment and psychotherapeutic treatment from multidisciplinary programs is not available (Coyle, 2000; Silk et al., 2000). In fact, Zito and colleagues (2000) documented a significant increase in the use of psychotropic drugs in children ages 2 to 4 in two Medicaid programs and a managed care organization between 1991 and 1995, even though careful outcome research has not been done regarding the efficacy and long-term safety of these medications for this age population. Although some young children can benefit from psychotropic medications, children who do not receive skilled mental health assessments can be inaccurately diagnosed and prescribed inappropriate treatments.

Robert

Robert, age three years, eight months, was living in a foster home with three other foster siblings. The foster mother consistently described Robert as being hyperactive and extremely aggressive. He was hospitalized, and the treating psychiatrist diagnosed him with Bipolar Affective Disorder and Attention Deficit Hyperactive Disorder and placed him on three psychotropic medications. Robert's sensitive and dedicated Children's Social Worker sought consultation with a TIES for Adoption team, consisting of a psychiatrist, social worker, pediatrician, and psychologist. Following this consultation and evaluation, the Children's Social Worker moved Robert to a nurturing fost/adopt home after she realized that the foster placement and the psychiatric regime was not meeting his needs. Two years later, Robert is free of all medications and has adjusted well to his new family. He is indeed an active little boy, but this does not appear to interfere with his learning, or his family or peer relationships.

Scarce Post-Adoption Support Services

Clinicians and researchers working in the field of adoption agree that services provided to adoptive families are critical—particularly for children with behavioral and emotional problems. The services families need include adoption sensitive mental health services, parent education and training, behavior management training, parent/child support groups, medical care, educational advocacy, case management, and respite care (Nelson, 1985; Christian & Ekman, 2000; Howard &Livingston, 1997; McCarty et al., 1999; Edelstein et al; 2000). Without accessible and quality services, the families of special-needs children often report that they feel isolated and abandoned.

The recent legislative and policy commitment to permanency for children in foster care, and the corresponding increase in the number of children who are being adopted, should not be followed by an increase in adoption disruptions and dissolutions because of inadequate availability of support services.

Although federal law requires that all children with special needs adopted from foster care have health insurance (California provides Medi-cal and adoption subsidies to these children), adoptive families frequently have great difficulties obtaining the services needed and have to contend with long waiting lists. The obstacles are similar to those faced by children in foster care, including a scarcity of service programs, low reimbursement rates for Medi-Cal services, and a disjuncture between the level of need of some children and the inadequacy of the payment subsidy.

VI. Innovative Approaches

Very young children in the child welfare system could benefit from specially designed services to meet their needs. Foster care and adoption practices, as described above, are rife with flaws that need significant political, administrative, and fiscal attention by public policymakers and other officials. Whether or not wholesale changes in the child welfare system are forthcoming, many smaller changes in the system could benefit young children. Below we describe three programs that are making a difference in the lives of very young children who have been maltreated.

Two of these programs exemplify interdisciplinary and interagency approaches that remedy some of the fragmentation of planning and care that many young children experience when they enter the system. These programs also focus on serving the special needs of young children in foster care and adoption in a developmentally appropriate manner across multiple domains of development. In both of these programs services are provided to the young child as well as caregivers in order to facilitate attachment and relationship formation in accordance with recommendations by child mental health authorities (Luthar & Cicchetti, 2000; Shirk, Talmi & Olds, 2000). Two of these projects are also beginning to gather much-needed data on characteristics of the children served and the impact of such services on the children and families. The third program addresses a crucial gap in support services that many foster and adoptive families identify as they deal with the stresses of parenting young children with special backgrounds and needs.

The Center for the Vulnerable Child – The SEED Project

In 1986, The Center for the Vulnerable Child (CVC) was established at Children's Hospital Oakland to address increased child abuse/neglect, family substance abuse, and the subsequent impact on the health, mental health and development of young children and families (Halfon, Mendonca & Berkowitz, 1995). Since its inception, the CVC has served hundreds of children in foster care and their families. From 1991 to 1998, the CVC conducted a services research project, supported by the National Institute of Mental Health (NIMH), to study the impact of CVC's intervention on young children in foster care and their families. CVC's Foster Care Program services were designed to

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increase the stability of children's foster care placements, improve children's development and mental health, and enhance caregiver's skills in parenting.

About 300 children (age range newborn to three years) and their families (foster, adoptive, relatives, and reunifying biological parents) received an array of family-centered flexible interventions that were home and center-based. The focus was on parent guidance and education, supporting healthy child/parent relationships, providing information on child development and the impact of trauma and grief on young children, and case management and coordination of services. All families received at least monthly contact with their primary CVC clinician and were offered twice-monthly support and education groups and weekly child respite care at CVC. A pediatric well-child Foster Care Clinic, staffed by physicians and CVC case managers, was also available to families. All children received an annual assessment of mental health and development. CVC staff collaborated with county child welfare workers for service coordination and placement planning.

Although the evaluation of the NIMH project did not demonstrate strong or consistent results in improving children's development or placement stability, foster parents who received CVC services demonstrated improved ability to read their children's signals and respond to their children's needs. The study design was based on comparing two samples of children, intervention and comparison, for whom there was a complete set of data. The difficulty of obtaining complete data, due in large part to multiple placement changes and highly overwhelmed families, was not anticipated and, unfortunately, reduced significantly the size of the comparable samples (Klee et al., 1998).

Despite these disappointing results, much was learned about providing services to young children in foster care. Project data did show that children faced more devastating developmental problems than had been expected on baseline measures of development, behavior, and need for services (Klee et al., 1997). Foster parents had more demands on them and far fewer resources than expected and the large caseloads and high turnover rate among child welfare workers in the county's agency impeded efforts to offer coherent services.

In 1997, CVC and Alameda County's child welfare agency began to design a new more collaborative program for young children in foster care based on the experiences of providing services under the NIMH project, and in the context of the new federal and state mandates of fast-track adoption and concurrent planning.

Improving upon the original program, CVC developed a new model, SEED (Services to Enhance Early Development) in order to place the child's needs at the center of case planning efforts and to create a close working relationship between CVC clinical staff and county child welfare workers. SEED is a three-year (1998-2001) collaborative project between CVC and the county's child welfare agency and is funded by the Stuart Foundation. The clinical team consists of CVC staff and child welfare workers. The program serves 100 children, from age birth to three years; the goal is for children to achieve permanent positive placements (reunification, adoption, relative placements) as soon as possible. Child welfare workers remain with the child until permanent placement occurs and carry a reduced caseload of 20 children. A public health nurse is part of the SEED team. The CVC services described above are available to SEED children and families, and a combined clinical team

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Sam and Mo

Sam and Mo, twin boys, were 2 years old when they came into the SEED project, along with their 3-year-old sister, Keisha. All three children had been severely neglected since birth. Their birth mother had a history of criminal activity and drug use; their birth father had a history of drug-induced psychotic episodes. During the time when children should be learning their first lessons of trust and love from their parents, these siblings were enduring a nightmare of domestic violence and severe neglect.

Finding a permanent placement for a sibling group of three is a difficult but important goal. The child welfare agency made two attempts to reunify these children with their birth parents. The first of these attempts ended when their mother was arrested and then jailed for operating a methamphetamine lab from her home. The children were then placed with their father, who had a psychotic break soon after, necessitating the children's removal. Between reunification periods the children had multiple foster care placements.

Given typically overburdened caseloads, the children's complicated and serious emotional needs, and the shortage of appropriate foster and adoptive home, these children would likely have been split up rather than placed together if it were not for a program such as SEED. SEED assessments identified the emotional and behavioral problems of the twins and the neurological and gross motor problems of Keisha. All three children were in need of psychotherapy to help them learn some of the lessons of trust and love they had been denied so far. Keisha also needed special education services, specialized medical care and occupational therapy. The SEED case manager arranged for these services soon after the children were enrolled in the program.

Within three months of enrollment into SEED, the children were placed with Evelyn, a 60-year-old first-time foster parent who lived with her adult daughter and a grandchild, and who had an adult son living nearby. The SEED team eased the transition both for Evelyn and the children. The psychologist evaluated each of the three children and served as a sounding board and mental health consultant for Evelyn as she struggled to understand the children's emotional needs and find strategies to support them. The SEED case manager supervised the children's visits with their birth mother, acting as a buffer between the two families until a determination was made by the courts about their permanent placement. The case manager will continue to act as a liaison with the schools and medical professionals who are providing a variety of services to these children.

Evelyn fell in love with the children and was determined to keep them if their birth mother was not able to put her life back together. One year after the children entered SEED, parental rights were terminated. Despite the enormity of the task she has set for herself, Evelyn is in the process of adopting this challenging and lovable group of three siblings, who now have every chance of living good and rewarding lives.

meeting of CVC and child welfare staff is held weekly. All the children receive annual assessments of their development and mental health in the context of their family and relationships. Assessment results are regularly discussed at team meetings to ensure that the focus on children's needs is an essential part of case planning. SEED has been a successful, effective collaboration between the CVC and the child welfare agency that is based on mutual trust, sharing responsibility for difficult cases,

availability of more relevant and shared information about children and families, and opportunities for clinical consultation among team members.

A testimony to the success of SEED is the implementation of a second SEED unit in the child welfare agency, SEED II, that will serve 60 children age birth to five years. SEED II is funded in part by Alameda County's Every Child Counts (Proposition 10). A third SEED unit is already being envisioned. It is encouraging indeed that a strong focus on the needs of young children and a collaborative approach to providing services are becoming part of how the child welfare agency wants to do business in the future (Kronstadt & Orfirer, 2000).

TIES (Training, Intervention, Education and Services) for Adoption

The TIES for Adoption program has served about 300 children since its inception. Not all families received the full TIES Transition Model; some received only interdisciplinary record review and consultation or multidisciplinary developmental assessment. Some families received services months or years after placement. Evaluation data from the program show promising results.

While TIES for Adoption services provide an important bridge for adoptive families, demand for these services far outpace funding availability. In Los Angeles County alone, 8,600 children were in foster care awaiting adoption in 1999. Many of these children and families could have benefited significantly from services such as these.

TIES for Adoption Evaluation Data

- Impact of Preparation Sessions: The three TIES for Adoption parent training sessions, offered 10 times in 1999 and 2000, were attended by 235 prospective adoptive parents, diverse in terms of ethnicity, family composition and educational attainment. Questionnaire data indicated that as a result of the preparation sessions, prospective parents (1) felt significantly better able to handle the challenges of adopting and parenting a child with prenatal substance exposure and (2) showed a significant increase in optimism about and sympathy toward children and adults affected by substance abuse as a result of the preparation sessions.

- TIES Transition Services Outcome Data: Extensive 1-year follow-up data are available for 24 children and their families who received transition model services. The majority of children were under 5 years of age at placement. Most had three or more previous placements, while almost half had experienced abuse or neglect in addition to prenatal substance exposure. Children and families were assessed at 2 and at 12 months after placement.

- Data indicate that developmental and behavioral outcomes for children with prenatal substance exposure improved significantly from 2 to 12 months after placement with services to parents provided during the transition and following placement. Parents reported significantly less parenting stress and increased satisfaction with the adoption at 12 months after placement than at 2 months after placement.

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- The majority of the parents cited TIES for Adoption as the most helpful resource in adapting to being an adoptive parent. All parents, responding to an anonymous survey regarding satisfaction with services, reported that they found TIES services either helpful or extremely helpful.

These outcome data, though based on a very small sample at this point, are encouraging, suggesting that young special-needs children adopted from foster care thrive in adoptive placements when they receive appropriate care, nurturance and stimulation and have the chance to develop a stable attachment to caregivers. However, in the absence of a control group, it cannot be determined to what extent the children's cognitive gains and behavioral improvements were due to the experience of a stable adoptive placement versus the contribution of the support services. The parents' significant decrease of stress around parenting these special-needs children suggested an increasing sense of competence and comfort in parenting the children, which would likely promote the continuing stability of the placements.

Clinically, many parents and clinical social workers stated that some placements would not have weathered the difficulties of the transition time without the help of TIES. The disruption rate (3%) for families participating in TIES is much lower than the 10 to 20% rates generally reported for placement of children beyond infancy (National Adoption Information Clearing House, 1998). Further research based on a large sample size and following the children yearly until 5 years post-placement is under way but is jeopardized by lack of ongoing funding. The addition of a matched control group that does not receive services would help determine the contribution of support services to the children's improved functioning, over and above the effects of adoptive placement. Such a research effort would require specific and extensive research funding.

Respite Care

Many foster and adoptive families report that they have difficulty finding affordable respite care and child care. Respite care provides parents with short-term relief from their parenting responsibilities, and may offer children an opportunity for some enriching activities with people outside their immediate family. Child care may be necessary when children have counseling and other appointments but the other children in the family cannot be brought along. Foster and adoptive families most in need of these services are those who have assumed the care of children with serious medical, emotional and/or behavioral problems. Many parents of special-needs children state that they are not able to take time out to meet their own needs because it is so difficult and costly to find child care providers who can handle the children. Also, sitters often refuse to return because of the children's challenging behaviors. The inability to locate respite and/or child care can lead to emotional depletion of parents and create problems in marriages, friendships, employment, and other sources of social support. The ensuing stresses can even put the foster or adoptive placement at risk of disruption (Howard & Livingston, 1997).

Respite care may take various forms and be tailored to the individual needs of children and families. In formal respite programs, the caregivers are usually licensed childcare providers, trained professionals or foster parents who care for the child in the family home or another setting. An informal model of providing respite care may use friends or relatives as the caregivers, while still

abiding by state legal requirements for these child care providers. Regardless of the particulars of respite care, effective models for foster and adoptive families must take into consideration the unique emotional and developmental needs of the foster and adopted children. The children are susceptible to feelings of abandonment, rejection and loss and the parents may be uncomfortable about allowing others to care for the child. Respite care needs to be accessible, flexible, and affordable, as well (Howard & Livingston, 1997).

An example of a comprehensive respite program is one provided by a project entitled Arizona's Aid to Adoption of Special Kids. This project, funded by the Arizona Adoption Subsidy Program, the State of Arizona Department of Developmental Disabilites, the Federal Adoption and Safe Families Act — ASFA (P.L. 105-89), matches individual families with trained respite providers who may be extended family members or a provider matched by the program. The providers are carefully screened and parents are involved in the selection and 18-our training of the respite provider. Respite care is arranged by the family when the need arises, in any time blocks the family prefers. Services are provided in the family home or in the provider's home, and providers are encouraged to develop long-term relationships with the family. The respite project at Aid to Adoption of Special Kids in Phoenix, Arizona, reports promising findings and very satisfied adoptive parents. Providers were also pleased with the project as they received relevant training, they enjoyed their relationships with families, and the compensation provided was adequate. Because of the success of this program, the Arizona state legislature recently enacted legislation authorizing respite care for all adoptive families with special-needs children. The model could be translated to California with beneficial effects for many families.

VII. Practice Paradigms to Improve Child Well-Being

The child welfare system is at a critical juncture. There is increasing support to provide preventive services early on, before families are in serious trouble. There is also a growing sensitivity to the developmental needs of children, and to the unique circumstances of very young children touched by the child welfare system. For young children to emerge from contact with the child welfare system *better off* than if they had been left alone—not just in terms of safety, but also in terms of their physical, psychological and emotional well-being—is the real test of the system's success.

Many opportunities exist to change the developmental trajectory of children who are maltreated by their families. Model programs have been developed, such as those described previously as well as many others (Howard & Smith,1997; Silver, Amster & Haecker, 1999; Christian & Ekman, 2000; Barth, Freundlich & Brodzinsky, 2000; Georgetown University Child Development Center, 2000), but most of these are still in the pilot phase and have neither been adequately evaluated nor brought up to scale. Each community will need to assess the suitability of these or other valuable new approaches against the cultural standards of their locality. Some principles of service design should be considered throughout the service delivery continuum:

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Maximize Opportunities for Prevention

Preventive efforts should be made to reduce the number of children who are placed in out-of-home care. Relying upon the groundbreaking research of David Olds (1999), public policy makers at the national, state, and local level are recognizing the significant gains that may be realized for children and families through home-visiting programs. These programs, which provide prenatal and hospital assessment, followed by long-term in-home services for families, show considerable positive results. Specifically, rates of child abuse and neglect may be reduced for families who participate in these programs.

Other opportunities to promote healthier families and reduce maltreatment may include developmental and behavioral assessments and services built in to regular well-child visits. Identification of high-risk children and families would be aided by the presence of child development specialists and/or social workers on site at pediatric offices and clinics in high-risk areas. Parenting education services by child development specialists, preschool teachers, social workers and psychologists who are culturally sensitive and familiar with the community need to be made available and easily accessible in churches, preschools, child care centers and at WIC sites. Parenting education could also alert parents to resources available through websites such as zerotothree.org or preventiveoz.org, a site that helps parents understand their children's temperaments and use parenting strategies appropriate for their child's temperament). Another tool could be "warm lines" which might help parents through challenging times (Kaufman, 2000), but care needs to be taken so that they are specifically designed for the needs of foster and adoptive parents. Further, many local communities are working with private foundations and local government to establish family resource centers in order to provide a kind of "community living room," accessible to all community members (Rogers, Berrick & Barth, 1996), and offering an array of family support services.

Perform Early Needs Assessment and Intervention

Too many young children reported to the child welfare system receive few or no services. As discussed previously, many children's cases are screened out, or are investigated and document abuse and neglect but are then closed without follow-up services. A more supportive model would encourage shared responsibility between the public child welfare agency and a variety of local nonprofit service providers who could respond to identification of high-risk families with offers of voluntary services such as supportive home visits from specially trained social workers and child development specialists, and/or parent support groups led by culturally sensitive professionals and para-professionals in the community who have been specially trained to deal with parenting needs of high-risk, high-stress families. High-quality child care services and preschool programs need to be made available to these families.

For young children entering foster care, developmental and emotional assessments are crucial shortly after entry into the system, as recommended by the American Academy of Pediatrics (2000) and the Child Welfare League of America. These assessments need to be performed by professionals who have special training in evaluating the needs and development of very young children in all areas of

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functioning. Preventive mental health services and early intervention for developmental delays can be extremely powerful in remediating deficits, but appropriate referrals to resources such as a regional center depend on timely assessment. With very young children, every week that intervention does not occur is a lost opportunity.

Plan for Young Children's Mental Health Needs

The child welfare system attempts to enhance children's well-being by protecting children from maltreatment, supporting families and promoting permanency for children. However, these services have not addressed problems and deficits in physical, developmental and mental health functioning that have already occurred when children become involved in the child welfare system. Preventive and ameliorative services that focus on children's mental health in a developmental context need to be available to this vulnerable population.

Services offered need to recognize the crucial role of forming relationships and healthy attachments in healthy development of young children. Often, when children have been neglected and maltreated, they establish ways of interacting with other adults that were adaptive in their troubled environment but are not in the context of another relationship. Caregivers need special support in recognizing and responding to the children's needs even though the child may appear to be rejecting them (Dozier, 2000). Efforts to just deal with the child's behavioral symptoms are not sufficient. Treating young children in their relational context and improving their transactions with their caregivers constitutes treatment of current problems as well as prevention of subsequent difficulties (Emde, 1990; Emde & Spicer, 2000; Luthar & Cicchetti, 2000).

Build Collaborative, Interdisciplinary, Interagency Service Delivery Models

Collaborative, interdisciplinary, interagency models should be the hallmark of early intervention services. These kinds of models are needed for many families: a birth parent struggling with a substance abuse problem while pregnant or parenting; a grandparent raising a toddler because of the mother's absence or incapacity; a new adoptive parent attempting to build a relationship with a 3-year-old child. These families face a variety of challenges, and they often need coordinated services from health care professionals, substance abuse treatment providers, mental health professionals, child care and early intervention specialists, and child welfare professionals. A case manager may need to coordinate and oversee that needed resources are accessed for the child (and family) and that the various agencies involved do not work at cross-purposes.

Intervene at Important Transition Points for Children

For young children who are placed in foster care, those moving from one foster home to another, or children moving to an adoptive placement, developmentally sensitive and preventive services should include a continuum of care that encompasses early identification of problems, treatment, and monitoring of the child's development and well-being. Times of crisis and transitions, in general, are periods of vulnerability and opportunity for young children and parents (Schneiderman et al., 1998). Preventive mental health services should begin early, during the transition to out-of-home care. While

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all children may need special supports as they transition from one home to another, young children and their caregivers need particularly focused attention. Mental health service systems currently in place generally do not provide such preventive services at major transition points unless the child has been diagnosed as having a mental disorder. Crucial transition times, however, are dramatic opportunities to alter the vulnerable child's developmental trajectory.

Caregivers need to get training on the special attachment and loss and grief issues faced by children moving from one home to another. Counseling support for caregivers is crucial in helping them understand, tolerate and deal with the child's emotional needs and reactions. As these new families are forming, parents also may be especially receptive to information and support. When reintegration of the child into their birth family is planned, birth parents may need extended after-care services in order to facilitate a successful reunification.

Thoroughly Prepare Caregivers to Support Children's Needs, Strengths and Vulnerabilities

Efforts to improve children's experiences in out-of-home care and through adoption include greater emphasis on preparation for foster and adoptive parents. Both foster and adoptive parents need education about young children's needs and development, and the importance of warm, nurturing and responsive relationships. They need to be helped to understand their special role in ameliorating children's difficulties resulting from disturbances in previous attachments. They need initial and ongoing training and supports provided through comprehensive specialized programs such as the first two innovative projects described above, warm lines (discussed previously) and other service programs – just as birth families need support and advocacy during the early years of child rearing.

Caregivers require complete information on children's history, their health, mental health, and developmental status. Development of a comprehensive system of "health passports" that travel with the child would be critical in ensuring that vital physical, mental health, and educational data, as well as placement history information, are available to social workers, caregivers and treating clinicians. It has been recommended that an Internet Passport, using existing state technology (with appropriate safeguards for confidentiality), could be very effective since it is would be an interactive system that would allow providers to input and access relevant information (Los Angeles County Children and Families Commission, 2000; Institute for Research on Women and Families, 1998).

Support Health, Developmental and Mental Health Evaluations

Thorough health, developmental, and mental health evaluations should be regularly conducted by skilled interdisciplinary teams knowledgeable about very young children in the child welfare system so that children's otherwise undetected service needs are quickly identified and addressed. These interventions can help to prevent foster and adoptive placement disruptions, as well as re-entry back to foster care. Knowledge of children's mental health and developmental status can help parents better understand young children's challenging and puzzling behaviors and provide a nurturing environment for the child.

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Provide Specialized Training of Child Welfare Workers and Other Professionals

One study of child welfare workers in California found that very few staff are offered training in child development and many professionals are unaware of the developmental milestones that should be expected among young children (Berrick et al., 1998). Further, schools of social work, which train large numbers of child welfare workers across the state, do not routinely offer child development courses for students.[5] In order to provide responsive care that continuously builds on children's developmental progress, child welfare staff and other involved professionals should be well trained in child development issues. In addition, training needs to be offered on the special needs that infants, toddlers, and preschoolers may bring to care, including issues pertaining to substance exposure, special health and mental health needs, attachment issues, and the affective needs that may be intensified for children who have experienced maltreatment. Training also needs to include information about the unique roles of, and strategies for, working effectively with interdisciplinary professionals, and a discussion of the importance of interdisciplinary approach to services for young children in out-of-home placement. Education should be carried out in social work schools, and in training for newly employed children's social workers. In addition, continuing education for all professionals dealing with young children in the foster care system should be offered on an ongoing basis.

Research and Evaluate Promising Prevention and Intervention Approaches

While some innovative approaches to facilitating optimal development in children in foster care or adoptive placement are developing, little actual data from well-developed and -executed program evaluations is available. Research is needed on interdisciplinary programs that follow children over time, take child and parent background factors into account, assess multiple areas of functioning (e.g., developmental, emotional, relational, physical), use multiple data sources (e.g., parents, intervention providers, observational data, etc.), specify the components of the intervention and evaluate the effects of various components, and compare outcomes for children and families receiving intervention with matched control groups. Such information would allow funders to give resources to programs with proven positive outcomes for our most vulnerable children. At present, uncertain and limited funding for programs with innovative approaches make time-intensive longitudinal evaluations difficult and necessarily limit research efforts.

Coordinate Fiscal Funding Streams and Mechanisms

Existing fiscal mechanisms need to be coordinated and integrated to assist with the development, and long-term fiscal solvency and availability of clinical services and programs for young children. Many funding possibilities already exist at the federal, county and state level, as well as through private foundations. However, innovative and model programs often require the blending of separate funding streams, each with its own mandates, eligibility requirements and restrictions. As new service programs are developed and refined, large amounts of energy and time are spent by senior

[5] Students, instead, are required to take a general, "Human Behavior and the Social Environment" course, which includes development across the lifespan.

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members of the staff, often experienced clinicians, on trying to find ongoing funding in order to sustain these critical services for young children. Proposition 10 could be enormously helpful in bringing together government and philanthropy in order to leverage their synergistic clout. Such a collaboration could facilitate funding of specific programs, test new programs being considered for dissemination, and brainstorm how to coordinate the complex but available funding streams (Kaufman, March 2000).

VIII. Funding Opportunities to Support Child Well-Being

Although there is an acknowledgment among child welfare professionals and the public that early intervention services could richly benefit families, there is currently insufficient federal funding to offer support to all children reported for maltreatment. Because the child welfare system is poised for change, funding from Proposition 10 could make a significant difference – either as a single funding source, or as leverage for other funding. As noted earlier, the majority of core child welfare funding is provided through Titles IV-B and IV-E of the Social Security Act. But children who are served by child welfare often have a variety of service needs that go well beyond core child welfare functions. Further, most funding mechanisms operate in silos, offering support for services that are predetermined, with relatively tight eligibility requirements and little flexibility.

A large array of funding programs are available to serve young children. Some provide funding for services, whereas others may be used for training. Services can be broken down into several areas, including (a) prevention, (b) early identification, (c) diagnosis, (d) treatment, or (e) rehabilitation. In Appendix B, we provide more detail about some of these funding programs as well as a table constructed by the California Department of Social Services that lists almost 40 funding opportunities available for children and families. Although funding is provided through a variety of sources, most child welfare professionals and researchers agree that current funding structures are insufficient to meet the needs of these vulnerable children.

With funding from Proposition 10, local communities can offer opportunities to children and families that are currently unavailable. Funding for current child welfare programs is so limited that many children must suffer multiple reports of maltreatment before their plight is considered sufficient to qualify for services. Rather than turning families away from child welfare agencies, Proposition 10 can help to develop or support a variety of community-based prevention programs, allowing young children to receive the vital health, mental health, and developmental services they need.

IX. Conclusion

In 1999, the Little Hoover Commission distributed a report entitled *Now in Our Hands*. The report chronicled the rapidly rising child welfare caseload and the increasing number of vulnerable young children forgotten by public child welfare agencies in our state. Each county in California now has an exciting opportunity to make a significant difference in the lives of tens of thousands of children.

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With the arrival of new resources fixed on the needs of infants, toddlers, and preschoolers, each community can resolve to make a difference: to promote healthy development for children, and to support children's cognitive growth in order to become school-ready. Abused and neglected children face pain and trauma at the hands of their parents—once identified by public officials, their plight is given over to "our hands." Proposition 10 can help to change the life trajectory of vulnerable children in many ways. Whether Proposition 10 dollars are leveraged with other resources in order to provide preventive services, to identify and remediate health and mental health needs, or to provide treatment and support during the major turning points and life transitions, each opportunity will have the potential to bring greater promise for our youngest, most vulnerable children.

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XI. Appendix A: Useful Organizations and Experts

Organizations

Children's Action Network
Phone: (800) 525-6789
E-mail: gabriela@childrensalliance.org

Dave Thomas Foundation for Adoption
(614) 764-8454

National Adoption Information Clearinghouse
Caliber Associates, Inc.
330 C St., SW
Washington, DC 20447
Phone: (888) 251-0075
Fax: (703) 385-3206
Web: www.calib.com/naic

North American Council on Adoptable Children
970 Raymond Avenue, Suite 106
St. Paul, MN 55114
Phone: 651-644-3036
Fax: 651-644-9848
E-mail: info@nacac.org

National Adoption Assistance, Training, Resource and Information Network
Phone: (800) 470-6665

Spaulding for Children/National Resource Center for Special Needs Adoption
16250 Northland Dr., #120
Southfield, MI 48075
Phone: (248) 443-7080
Fax: (248) 443-7099
E-mail: sfc@spaulding.org
Web: www.spaulding.org

Beth Hall and Gail Steinberg Pact, An Adoption Alliance
1700 Montgomery St., #111
San Francisco, CA 94111
Phone: (415) 221-6957
Fax: (510) 482-2089
E-mail: info@pactadopt.org
Web: www.pactadopt.org

Department of Social Services/Adoption
Child Welfare League of America
Phone: (202) 638-2952
Web: www.cwla.org

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The Evan B. Donaldson Adoption Institute
120 Wall Street, 20th Floor
New York, New York 10005
Phone: (212) 269-5080
Fax: (212) 269-1962
E-mail: geninfo@adoptioninstitute.org
Web: www.adoptioninstitute.org

Children's Bureau
Administration for Children and Families
U.S. Department of Health and Human Services
Web: www.acf.dhhs.gov/programs/cb

National Clearinghouse on Child Abuse and Neglect Information
Caliber Associates, Inc.
330 C St., SW
Washington, DC 20447
Phone: (800) 394-3366
Fax: (703) 385-3206
E-mail: nccanch@calib.com
Web: www.calib.com/nccanch

National Resource Center for Foster Care and Permanency Planning
Hunter College, School of Social Work
129 E. 79th St.
New York, New York 10021
Phone: (212) 452-7053
Fax: (212) 452-7051
E-mail: nrcpp@shiva.hunter.cuny.edu
Web: www.hunter.cuny.edu/socwork/nrcppab.htm

National Resource Center for Information Technology in Child Welfare Services
Child Welfare League of America
440 First St., NW
Washington, DC 20001-2085
Phone: (202) 638-2952
Fax: (202) 638-4004
Web: www.cwla.org

National Resource Center on Child Maltreatment
Child Welfare Institute
1349 Peachtree St., NE
Suite 900
Atlanta, GA 30309-2956
Phone: (404) 876-1934
Fax: (404) 876-7949
E-mail: NRCCM@gocwi.org
Web: www.gocwi.org/nrccm

National Child Welfare Resource Center on Family–Centered Practice
Learning Systems Group
1150 Connecticut Ave., NW
Suite 1100
Washington, DC 20036
Phone: (800) 628-8442
Fax: (202) 628-3812
E-mail: cwrc@esilsg.org
Web: www.esilsg.org

National Child Welfare Resource Center on Legal and Judicial Issues
ABA Center on Children and the Law
740 15th St., NW
9th Floor
Washington, DC 20005-1009
Phone: (202) 662-1746
Fax: (202) 662-1755
E-mail: markhardin@staff.abanet.org
Web: www.abanet.org/child

National Abandoned Infants Assistance Resource Center
University of California, Berkeley
School of Social Welfare
1950 Addison St.
Suite 104
Berkeley, CA 94704-1182
Phone: (510) 643-8390
Fax: (510) 643-7019
E-mail: aia@uclink4.berkeley.edu
Web: www.cssr.berkeley.edu/aiarc

National Resource Center for Community-Based Family Resource and Support Programs (FRIENDS)
Chapel-Hill Training Outreach Project
800 Eastowne Dr.
Suite 105
Chapel Hill, NC 27514
Phone: (800) 888-7970
Fax: (919) 968-8879
Web: www.frca.org/friends.htm

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XII. Appendix B: Child Welfare Funding Information

The last page of this appendix contains a table that identifies funding sources for services for young children in foster care and adoption. The following glossary describes the funding sources identified in the table and how they are and may be used.

Title IV E - Foster Care - Authorized by Social Security Act - Covers training for agency staff and foster parents involved in State's foster care program

Title IV E - Adoption Assistance - Authorized by Social Security Act - Covers training for agency staff and adoptive parents involved in the State's Adoption Assistance program. The eligible population is foster children with special needs based on age, ethnicity, physical/mental disabilities, and/or membership in a sibling group

Title XX - Block Grants to States for Social Services - Authorized by Social Security Act - May be used to support child welfare programs and staff training

Medicaid (Medi-Cal) - Authorizing Statute - Authorized by Social Security Act - Provides Federal funding for health care services for low income and indigent individuals. All dependent children of the court are eligible for Medi-Cal. All children under the age of 21 enrolled in Medi-Cal are entitled under federal law to receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (42 US.C.A. section 1396). EPSDT is a comprehensive benefits package that requires medical, mental health, developmental, vision, hearing and dental screens to be performed at distinct intervals. EPSDT requires state Medicaid agencies to assure the provision of necessary treatment for both physical and mental health conditions to the extent required by an individual child (42U.S.C.A.Section 1396d)

Women, Infants, and Children (WIC) - A federally authorized and funded program to promote optimal growth and development in young children. Eligibility criteria are nutritional risk and low income. All foster children (to 18 months of age without medical problems) are eligible if their foster parents receive $1,000 or less per month for the child's care.

AB3632 – Authorized by California Law - The County Department of Mental Health is responsible for providing mental health services for seriously emotionally disturbed students.

California Children's Services (CCS) - Authorized by Health and Safety Code and California Code Regulations - Covers children under 21 years of age who have a handicapping condition and whose families are partially or totally unable to pay for services

Individuals with Disabilities Education Act (PL101-476) (IDEA) – Children from birth to age three who have a developmental delay or a condition with a high probability of resulting in developmental delay are entitled to early intervention services under Federal and State law. Children age three through five who have a disability in one or more domains can receive special education and related services under the Federal Preschool Grants Program. PL99-457 stipulates that states must provide

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services to all 3-5 year old children with disabilities to receive any federal special education funding. Part C of the IDEA Amendments of 1997 (PL105-17) provides funds to states to develop programs for infants and toddlers with disabilities and to implement a statewide, comprehensive, coordinated, multidisciplinary, interagency early intervention program. Also included is the goal of enhancing the capacity of families to meet the special needs of their very young children.

Options for Recovery Project - Chapter 606 (AB 67) - Provides funds for the recruitment, training and respite care for foster parents to care for children who have medical problems related to drug or alcohol exposure or to AIDS.

Substance Abuse/HIV Child Adoption Program (AB 2198 Chapter 1014) - Extends the Options for Recovery Program services to adoptive and preadoptive parents. Provides funding to counties in California to replicate the TIES for Adoption program.

Federal Adoptions and Safe Families Act (PL105-89) - Authorizes the incentive payments to states that increase the number of adoption s of children in foster care. Chapter 1056 (AB2773) indicated the incentive payments allocated to California be used for post-adoptions services.

Head Start - As Medicaid eligible, foster children and many children in adoptive placement meet Head Start's eligibility requirements.

Child Abuse Prevention and Treatment Act (CAPTA) - Authorized by Federal Law to provide funds to states for child abuse prevention programs

Funding Sources for Services for Young Children in Foster Care and Adoption

	SERVICES			TRAINING	
	MEDICAL	**MENTAL HEALTH**	**EDUCATIONAL/ DEVELOPMENTAL**	**TRAINING CAREGIVERS**	**TRAINING STAFF**
REHABILITATION	Medi-Cal, EPSDT, CCS	EPSDT, IDEA, AB 2773	IDEA, EPSDT, AB 2773	IV-E, IDEA, AB 2773	IV-E, TITLE XX
TREATMENT	Medi-Cal, EPSDT, CCS	IDEA, EPSDT, Medi-Cal, AB 2198, AB 67, IV-B, AB 2773	IDEA, EPSDT, AB 2198, AB 67, IV-B, AB 2773	IV-E, IDEA, TITLE XX AB 2773, AB 2198, AB 67	IV-E, IV-B, AB 2198, AB 67, TITLE XX
DIAGNOSIS	Medi-Cal, EPSDT	EPSDT, Medi-Cal AB 2198, AB 67, IV-B, AB 2773	IDEA, EPSDT, AB 2198, AB 67, IV-B, AB 2773	IV-E, TITLE XX, AB 2198, AB 67, AB 2773	IV-E, IV-B, TITLE XX
EARLY IDENTIFICATION	EPSDT, Medi-Cal	IDEA, EPSDT, AB 2198, AB 67, IV-B, AB 2773	IDEA, EPSDT, AB 2198, AB 67, IV-B, AB 2773	IV-E, TITLE XX, CAPTA, AB 67, AB 2198, IV-B, AB 2773	AB 67, AB 2198, IV-E, IV-B, TITLE XX

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